

WILHEIT STUDENT SERVICES SCHOOL REFERRAL FORM

FAX TO 678-943-8705 WHEN COMPLETE

Name of Referral Source & Referring School: _____

Today's Date: _____ Time: _____ Student's Grade: _____

Full Name of Student: _____ DOB: _____
Last First Middle

Address: _____ City: _____ Zip: _____

Phone 1: _____ Home Work Cell

Phone 2: _____ Home Work Cell

Name of Parent/Guardian 1: _____ Relationship to Student?: _____

Name of Parent/Guardian 2: _____ Relationship to Student?: _____

Nature of Problem: (Please circle any that apply)

- 1) Academic 5) Vocational/Career 9) Emotional stress – worry, 11) Impulse control/antisocial behavior
- 2) Family 6) Parent-Child Issues depression, anxiety 12) Trauma
- 3) Relationship - Friends 7) Anger/Aggression 10) Relationship - Dating 13) School
- 4) Substance Abuse 8) Low Self-esteem 14) ADHD/Learning Disabilities

Other: _____

If Applicable

Legal action pending? Yes No Unknown

DFCS Involvement? Yes No

If yes, please explain: _____

Previous counseling contacts? (Names if known):

1) Psychiatrist 2) Psychologist 3) Minister 4) Social Worker 5) Counselor 6) None

Current Medication(s) _____

Prior Hospitalization(s)? Yes No If yes, when? _____

INTERNAL USE ONLY

Appropriate Referral? Yes No

Assigned Intern: _____

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